

2020-2021 PROVIDER POLICIES AND GUIDELINES ACKNOWLEDGMENT FORM

| FACILITY INFORMATION | |
|---|-----------|
| Facility Name: | VFC Pin#: |
| <p><i>By signing this form, I certify on behalf of myself and all immunization providers and staff at this facility, I have read and agree to comply with the current Idaho Immunization Program (IIP) Provider Policies and Guidelines.</i></p> <p><i>In addition, I understand the current Provider Policies and Guidelines supersedes any prior IIP policies and guidelines. I further understand that content and forms referenced may be updated or modified at any time. Updates and revisions will be communicated to my office through announcements in Idaho's Immunization Reminder Information System (IRIS); and/or Provider Updates published by the IIP; and/or direct mail, email, and/or fax.</i></p> | |
| Medical Director or Equivalent | |
| Name (please print): | |
| Signature: | Date: |
| Primary Vaccine Coordinator | |
| Name (please print): | |
| Signature: | Date: |
| Back-up Vaccine Coordinator | |
| Name (please print): | |
| Signature: | Date: |